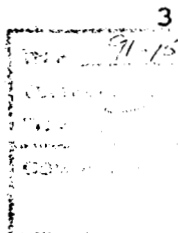


accordance with state and federal requirements.

- E. Financial management system which provides documentation of services and costs.
- F. Capacity to document and maintain individual case records in accordance with state and federal requirements.
- G. Demonstrated commitment to assure a referral consistent with section 1902a(23), freedom of choice of providers.
- H. A minimum of three years experience demonstrating capacity to meet the case management service needs of the target population.
- I. Qualifications of Case Managers
  - 1. Completion of training in case management curriculum approved by the Office of Medical Assistance Programs.
  - 2. Basic knowledge of behavior management techniques, family dynamics, child development, family counseling techniques, emotional and behavioral disorders.
  - 3. Skill in interviewing to gather data and complete needs assessment, in preparation of narratives/reports, in development of service plans, and in individual and group communication.
  - 4. Ability to work with court systems, to learn state and federal rules, laws and guidelines relating to child welfare, and to gain knowledge about community resources.



Additional Assurance (Section G of Supplement 1, State Plan Preprint)

Payments for targeted case management will be made through the MMIS system. The state Medicaid agency assures that no case management administrative activities will be billed as targeted case management services. SOSCF will utilize the Random Moment Time Sampling process to allocate case management administrative activities as separate costs, distinct from targeted case management services. Other providers of targeted case management must also provide assurances that they will not bill other federal programs. Payments for targeted case management will be made through the MMIS system to all qualified provider organizations. Use of this system assures that duplicate payments will not be made to more than one provider for targeted case management services provided to the same client.

96-03  
~~91-13-23~~

Approved: 4-4-96

Effective: 1-1-96

**TARGETED CASE MANAGEMENT SERVICES FOR MEDICAID HIGH RISK INFANTS AND CHILDREN**

**Target Group (Section A of Supplement 1, State Plan Preprint)**

Targeted case management services will be provided to all Medicaid eligible infants and preschoolers through three years of age who are at risk of poor health outcome.

**RISK CRITERIA**

**MEDICAL RISK FACTORS**

Drug exposed infant  
Infant HIV Positive  
Maternal PKU or HIV Positive  
Intracranial Hemorrhage (excludes Very High Risk Factor B16)  
Seizures (excludes VHR Factor B18)  
Perinatal asphyxia  
Small for gestational age  
Birth weight 1500 grams or less  
Mechanical ventilation for 72 hours or more  
Neonatal hyperbilirubinemia  
Congenital infection (TORCH)  
CNS infection (e.g., meningitis)  
Head trauma or near drowning  
Failure to thrive  
Chronic illness  
Suspect vision impairment  
Vision impairment  
Family history of childhood onset  
Hearing Loss

**SOCIAL RISK FACTORS**

Maternal age 16 years or less  
Parents with disabilities or limited resources  
Parental alcohol or substance abuse  
At-risk caregiver  
Concern of parent/provider  
Other

**DEVELOPMENTAL RISK FACTORS**

Borderline developmental delay  
Other

**ESTABLISHED RISK CATEGORIES**

Heart disease  
Chronic orthopedic disorders  
Neuromotor disorders including cerebral palsy & brachia nerve palsy  
Cleft lip and palate & other congenital defects of the head and face  
Genetic disorders including fetal alcohol syndrome  
Multiple minor physical anomalies  
Metabolic disorders  
Spina bifida  
Hydrocephalus or persistent ventriculomegaly  
Microcephaly & other congenital defects of the CNS  
Hemophilia  
Organic speech disorders (dysarthria/dyspraxia)  
Suspect hearing or hearing loss  
Burns  
Acquired spinal cord injury etc., paraplegia or quadriplegia

91-23  
10/30/91  
7/1/91

VERY HIGH RISK MEDICAL FACTORS

Intraventricular hemorrhage  
(grade III, IV) or cystic  
Periventricular leukomalacia  
(PVL) or chronic subdurals  
Perinatal asphyxia and  
seizures  
Oromotor dysfunction requiring  
specialized feeding program  
(include infants with  
gastrostomies)  
Chronic lung disease on oxygen  
(includes infants with  
tracheostomies)  
Suspect neuromuscular disorder  
including abnormal  
neuromotor exam at NICU discharge

Areas of State in Which Services Will Be Provided (Section B of  
Supplement 1, State Plan Preprint)

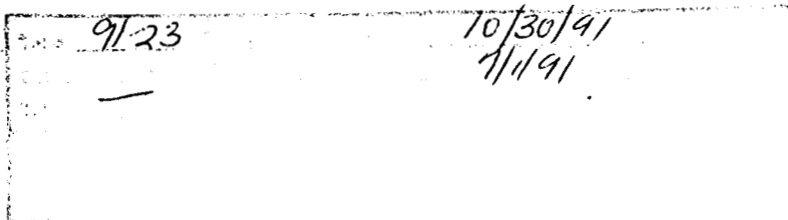
Entire State

Only in the following geographic areas (authority of S1915(g)(1) of  
the Act is invoked to provide services less than statewide):

Comparability of Services (Section C of Supplement 1, State Plan  
Preprint)

Services are provided in accordance with S1902(a)(10)(B) of the  
Act.

Services are not comparable in amount, duration and scope.  
Authority of S1915(g)(1) of the Act is invoked to provide services  
without regard to the requirements of S1902(a)(10)(B).



Definition of Services (Section D of Supplement 1, State Plan Preprint)

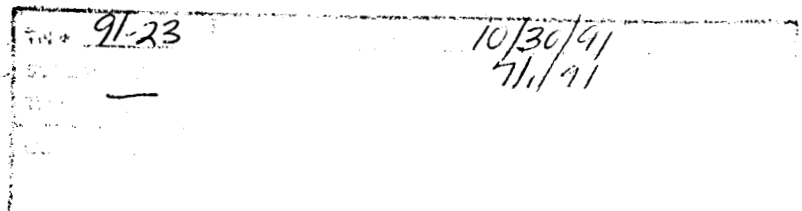
Required Case Management Activities

Case Management services must include:

1. Screening - Examination by single test or procedure in order to detect an unrecognized problem. Screening is not designed to diagnose the problem, but to sort the target population into two groups: those at risk for an particular health problem and those not at risk.

The case manager will screen the infant/toddler. The Medicaid agency has chosen to use standardized screening tools or to follow specific protocols approved by the Title V Agency.

2. Assessment - The systematic ongoing collection of data to determine current status and identify needs in physical, environmental, psychosocial, developmental, educational, behavioral, emotional, and mobility areas. Data sources include client interview, existing available records, and needs assessment.
3. Intervention
  - a. Linkage - establishing and maintaining a referral process with pertinent individuals and agencies which avoids duplication of services to clients.
  - b. Planning - Identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated, integrated fashion.
  - c. Implementation - Putting the plan into action and monitoring its status.
  - d. Support - Support is provided to assist the family to reach the goals of the plan; especially if resources are inadequate or the service delivery system is non-responsive.



Qualifications of Providers (Section E of Supplement 1, State Plan Preprint)

Case management provider organizations must be certified by the single state agency as meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management services including:
  - a. Comprehensive client assessment
  - b. Comprehensive care/service plan development
  - c. Linking/coordination of services
  - d. Monitoring and follow-up of services
  - e. Reassessment of the client's status and needs
  - f. Tracking and follow-up to assure that no client is lost to the case management system during the rapid developmental period of the first 47 months of life.
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population.
4. A sufficient number of staff to meet the case management service needs of the target population.
5. An administrative capacity to insure quality of services in accordance with state and federal requirements.
6. A financial management capacity and system that provides documentation of services and costs.
7. Capacity to document and maintain individual case records in accordance with state and federal requirements.
8. Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program.
9. Ability to link with the Title V Statewide MCH Data System or provide another statewide computerized tracking and monitoring system.

Manager Qualifications

The case manager must be a licensed registered nurse with one year of experience in community health, public health, child health nursing, or be a registered nurse or certified home visitor under the supervision of the above.

The case manager must work under the policies, procedures, and protocols of the State Title V MCH Program.

TN# 94-015

Approved: 1/20/95

Effective: 10/1/94

SUPERCEDED: 9/1/23

Freedom of Choice (Section F of Supplement 1, State Plan Preprint)

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of S1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.
  - (a) Approved S1915(b) waivers will apply to free choice of the providers of other medical care under the plan.

Payment (Section G of Supplement 1, State Plan Preprint)

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

9/23

10/30/41  
7/1/91

- Advanced HIV-related dementia-confusion, severe memory loss, aggressive behavior
- Need for assistance to ambulate and/or transfer between bed and chair
- Suicidal ideation with plan for action
- Need for assistance with activities of daily living based on severe fatigue and weakness
- Care providers/family members overwhelmed by needs of the person with HIV disease
- Uncontrolled pain
- Loss of ability to manage medically prescribed care at home (medication, skin care, IVs)
- Significant weight loss associated with frequent diarrhea, nausea, vomiting and/or anorexia
- Inability to maintain adequate nutrition
- Decreased mobility-potential for falls
- Presence of substance abuse in conjunction with advanced HIV disease
- Presence of chronic mental illness in conjunction with advanced HIV disease
- Complex family situations (e.g., both spouses or partners infected)
- Families with children affected by HIV (parent or child infected)
- Homelessness or inadequate housing/heat/sanitation
- Inability to manage household activities due to advanced HIV disease

92-9 4/28/92  
1/1/92

Areas of State in which services will be provided (Section B of Supplement 1, State Plan Preprint)

Only in the following geographic areas (authority of 1915(g)(1) of the Act is invoked to provide services less than statewide):

Services will be provided in Multnomah County.

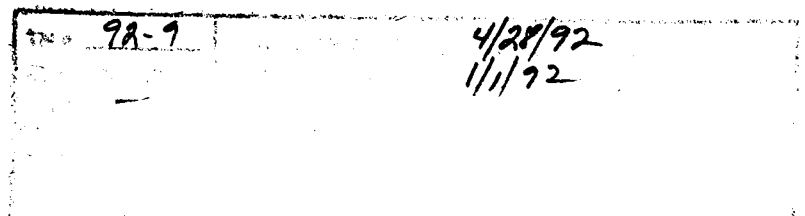
Comparability of Services (Section C of Supplement 1, State Plan Preprint)

Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(i) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

Definition of Services (Section D of Supplement 1, State Plan Preprint)

Case management services include:

1. **Assessment:** the systematic ongoing collection of data to determine current status and identify client's physical, psychosocial, and educational needs. An HIV nursing assessment tool will measure ability of the client to manage care at home including pain control medication management, nutritional needs, personal care needs, home safety assessment, coping with symptoms and disease process, as well as education and service needs that might enhance the client's ability to maintain an independent lifestyle as long as possible. Data sources will include client and support person interviews, information from the referral source, communication with health care team members, and existing available records.
2. **Comprehensive care/services plan development:** identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated integrated fashion. Emphasis is placed on client independence and client participation in planning of his/her own care. Natural support systems include family members, partners, and friends.



3. **Intervention/implementation:** putting the plan into action and monitoring its status. When possible intervention is provided in the home where retention of information is improved, the cost of clinic space is saved, and support persons can be included. Case management will not provide direct interventions but will identify, refer to, and arrange for needed support services such as:
  - Medication management systems, including safe levels of pain control
  - Nutritional support programs (teaching, meals on wheels, arranging for a volunteer)
  - Care plans for the coordination of volunteers
  - Disease specific education of clients and caregivers
  - Caregiver respite
  - Childcare
  - Grief and loss counseling
  - Personal care decisions
  - Benefits eligibility
  - Stress reduction
  - Mental health assessments
  - Substance abuse treatment
  - Spiritual counseling
  - Emotional support to clients, partners, and family members
  - Facilitating early hospital discharge by assuring that support systems are in place prior to patient discharge
  - Coordination of client care
  - Coordination of home health agency and hospice nursing services
4. **Coordination/linking of services:** establishing and maintaining a referral process with pertinent individuals and agencies to avoid duplication of services to clients, to assist clients in accessing resources, and to solicit referrals from the community into the managed care system. Support and coordination is provided to assist the client and service providers to reach the goals of the plan; especially if resources are inadequate or service delivery system is nonresponsive.
5. **Evaluation:** each visit will include a reassessment of the client's status and needs, review and update of the care plan, appropriate action and referral, and accurate record keeping.

92-9

4/25/92  
1/1/92